**Statement of**
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**Before the**
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**Committee on Government Reform**
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Mr. Chairman, Congressman Kucinich, Members of the Committee, thank you for this opportunity to discuss President Bush's unprecedented Emergency Plan for AIDS Relief, or PEPFAR. We have been grateful for the strong bipartisan support of Congress, including members of this Committee.

I am pleased to be here with Dr. Kent Hill, who leads the U.S. Agency for International Development's work to implement the Emergency Plan. The people of USAID, as well as those of the Department of State, the Department of Health and Human Services, the Department of Defense, Peace Corps and other implementing agencies, are a true interagency team, and their commitment has been a key part of the success of this initiative.

Fundamentally, it is the generosity of the American people that has created the largest health care initiative in history dedicated to a specific disease. What the President's Emergency Plan has accomplished in partnership with the people we are privileged to serve is – in a word – breathtaking.

Looking at just the 15 focus countries of the more than 120 countries where we have worked in the first two years of the Emergency Plan, we have seen remarkable results to date.

In addition to the prevention work that is the focus of today's discussion, we have supported **treatment** for over 560,000 thousand people – 61 percent of whom are women and 8 percent of whom are children.

We have supported **care** for three million, including 1.2 million orphans and vulnerable children. We have supported counseling and testing for 13.6 million – 69 percent of whom are female.

And these figures do not include work in the other countries with bilateral U.S. Government programs under the Emergency Plan, nor PEPFAR's support for the programs of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Other bilateral programs and the Global Fund are both integral components of the Emergency Plan. The success of the Global Fund is important to ensure a truly global response, by providing nations with few or no bilateral programs with a mechanism to contribute to what must be a world-wide effort.

Yet treatment and care for those already infected with HIV are not enough. Only a vigorous and comprehensive prevention approach will turn the tide against the global HIV/AIDS pandemic – the mission of the Emergency Plan. In addition to the humanitarian imperative to avoid suffering whenever possible, if we do not slow the rate of infections, it will be impossible to sustain the resources – financial, human, institutional – for the care and treatment of an ever-expanding pool of

infected persons. Ultimately, effective prevention is the only way to achieve the elusive goal of an HIV/AIDS-free generation.

Since President Bush's announcement of the Emergency Plan, the United States has demonstrated historic leadership in implementing the most diverse HIV/AIDS prevention strategy of any international partner. More than three and a half years ago, President Bush had the vision to insist that prevention, treatment and care be addressed together to ensure a comprehensive and effective response – an idea that now commands wide acceptance. The lessons learned from the intensive application of the Emergency Plan in the 15 focus countries are now being extended to over 120 countries, helping to fuel transformation of HIV/AIDS responses in nations around the world.

This unprecedented initiative dwarfs the pre-PEPFAR baseline levels of prevention spending and has allowed for a wide-ranging portfolio of high-quality, sustainable, evidence-based prevention programs.

PEPFAR's unparalleled financial commitment has permitted the USG to support a balanced, multi-dimensional approach – one that was not possible with pre-PEPFAR spending levels. The total annual spending in the areas of HIV/AIDS prevention, as well as treatment and care, has continually increased since the passage of the Leadership Act.

If Congress enacts the President's request for $4 billion in HIV/AIDS funding for FY 2007, that will represent a total increase of $740 million from that appropriated in fiscal year 2006 ($3.3 billion), and almost $1.3 billion from that appropriated in FY 2005 ($2.7 billion). In comparison with the FY 2001 total of $840 million for global HIV/AIDS, these PEPFAR levels of funding represent a quantum leap.

Before the advent of PEPFAR, the U.S. Government was supporting very few programs in care and treatment. Even with the massive and highly successful scale-up of these services with PEPFAR support, the USG commitment to global HIV/AIDS prevention is now clearly stronger than it has ever been. PEPFAR prevention funding in the focus countries increased from $214 million in FY 2004, to approximately $294 million in FY 2005, to $396 million in FY 2006.

Even so, there has been a significant constraint on prevention, treatment and care resources in the focus countries. Almost $527 million from focus country programs has been redirected to the Global Fund and other components of the Emergency Plan over PEPFAR's first three years. The President's FY 2007 budget request for the focus countries is, in part, a response to that history, in an attempt to mitigate the effects on focus country programs of the redirection of resources.

The effect of this trend has been to force country teams to make difficult trade-offs among prevention, treatment, and care. Within prevention, there have been similar trade-offs, and we appreciate the GAO Report's candor about these challenging decisions. In FY 2007 and beyond, full funding for focus country activities is essential if PEPFAR is to meet the 2-7-10 goals, including the prevention goal.

To be candid, if I accomplish nothing else today, I hope I will be able to persuade you of the importance of full funding for the focus countries to ensure effective prevention.

Now let me turn to what constitutes effective prevention. Prevention programs can only achieve results when they are community-led. Local management and participation means that programs are responsive to local culture and tailored to local circumstances. Locally-led programs can make full use of the passion and commitment of women and people living with HIV/AIDS, and help to build the

capacity of the non-governmental sector to contribute to a truly multi-sectoral response. And local leadership is required for effective prevention to be sustainable for the long haul – as it must be.

Effective prevention must squarely address the reality that the overwhelming majority of cases of HIV infection are due to sexual activity. Worldwide, far more than 80 percent of HIV infections are sexually transmitted. In sub-Saharan Africa, where HIV is generalized throughout the population rather than concentrated in easily-identified groups, the percentage is even higher. PEPFAR has a major focus on prevention of mother-to-child transmission, infection due to unsafe blood and medical injections, and infection due to injecting-drug use. Yet many of these infections can be traced back to earlier cases of sexual transmission. Truly effective prevention must address sexual risky behavior – it is at the heart of this pandemic.

The people of Africa have been leaders in developing a prevention strategy that responds to the special challenges they face – the "ABC" approach, which stands for "abstinence," "being faithful," and "correct and consistent use of condoms." In fact, the strategies of many nations in Africa and elsewhere included the ABC approach, delivered in culturally-sensitive ways, long before the advent of the Emergency Plan.

The past year has been a particularly important moment in the effort for sustainable prevention. We have long had evidence of large-scale behavior change in Uganda and Thailand, at the time when those nations were engaged in intensive behavior change efforts in the 1990s. Recently, however, impressive new Demographic Health Survey evidence from a growing number of nations is expanding the evidence base for the ABC strategy in generalized epidemics, such as those in most of Sub-Saharan Africa.

Recent data from Kenya, Zimbabwe, and urban Haiti show declines in HIV prevalence. A new study has concluded that these reductions in prevalence do not simply represent the natural course of these nations' epidemics, but can only be explained by changes in sexual behavior. This demonstrates the power of behavior change to save lives – and the importance of support for effective behavior change interventions.

In Kenya, the Ministry of Health estimates that HIV prevalence dropped by 30 percent over the five years that ended in 2003. This decline correlates with a broad reduction in sexual risky behavior including: increased male faithfulness, as measured by a 50 percent reduction in young men with multiple sexual partners; primary abstinence, as measured by delayed sexual debut; and secondary abstinence, as measured by those who had been sexually active but refrained from sexual activity over the past year; and increased use of condoms by young women who engage in risky activity.

In an area of Zimbabwe, the journal ***Science*** reported a 23 percent reduction in prevalence among young men, and a remarkable 49 percent decline among young women – also during the five years that ended in 2003. Again, the article correlates significant behavior change, consistent with the ABC approach, with the decrease in HIV prevalence.

Dr. Peter Piot, the Director of the Joint United Nations Programme on HIV/AIDS (UNAIDS), remarked with respect to these two countries, "[T]he declines in HIV rates have been due to changes in behaviour, including increased use of condoms, people delaying the first time they have sexual intercourse, and people having fewer sexual partners." Put another way, each of the ABC behavior

changes took place in these countries, and the combination added up to a significant reduction in the spread of the virus.

Among the most encouraging developments in many years in the global fight against HIV/AIDS is this growing body of evidence demonstrating that ABC behavior change is possible – and that it can reduce HIV prevalence on a large scale. Because of the data, ABC is now recognized as the most effective strategy to prevent HIV in generalized epidemics. One of the most striking findings of the GAO Report is the consensus among U.S. Government field personnel that ABC is the right approach to prevention.

To the extent any controversy remains around ABC, I believe it stems from misunderstanding. ABC is not a narrow, one-size-fits-all recipe. It encompasses a wide variety of approaches to the myriad of factors that lead to sexual transmission. The interventions that help people to choose to avoid the risk of HIV infection entirely, or to reduce their risk, vary according to the circumstances of their lives.

For example, the Emergency Plan recognizes the critical need to address the inequalities among women and men that influence behavioral change necessary to prevent HIV infection. While gender equity does not directly reduce HIV transmission, ABC is crucial for the protection of women. Within our ABC Guidance, it is clear that ABC programs should address gender issues including violence against women, cross-generational sex and transactional sex. Such approaches are not in conflict with ABC – they are integral to it.

Some of the most striking data presented at our recent Implementers' Meeting in Durban concerned behavior change by men – the "B," or "being faithful" element of the ABC strategy. In a number of places, men have begun to reduce their number of sexual partners – and the populations doing so include even some of the men at highest risk, such as long-distance truck drivers. As we seek to empower women for HIV prevention, reaching men with effective interventions is one of the most important things we can do – and this too is part of ABC.

ABC programs also address the issue of prevention for positives – helping infected people to choose whether to abstain from further sexual activity, or to be faithful to a single partner whose status is known and use a condom. ABC programs offer people information on how alcohol abuse can lead them into risky sexual behavior. ABC programs work with HIV-positive injecting-drug users so they can avoid sexual transmission of HIV.

And ABC programs link people to HIV counseling and testing, which is critical for prevention. Studies have shown that people who know their HIV status are more likely to protect themselves and others from infection.

Clearly, the ABC approach is a crucial foundation for our efforts. Of course, there is more to effective prevention. The U.S. Government supports the most diverse range of prevention approaches of any international partner. In addition to ABC, we support national strategies to prevent mother-to-child transmission of HIV and to prevent the transmission of the virus through unsafe blood or medical injections. The Emergency Plan also supports national strategies to address the risks posed by injecting-drug use, as well as many other issues.

As we look at the role of sexual transmission in the larger prevention context, I'd like to address the effect of the Congressional prevention directive. The authorizing legislation recommends that 20

percent of funding in the focus countries be allocated for prevention, and directs that at least 33 percent of prevention funding be allocated to abstinence-until-marriage programs. In 2004, we notified Congress that we count programs that focus on abstinence and faithfulness for this purpose, as A and B messages should always be delivered together except in programming for young children. This 33 percent requirement is applied across all the focus countries collectively, and PEPFAR has met it.

The legislation's emphasis on AB activities has been an important factor in the fundamental and needed shift in U.S. Government prevention strategy from a primarily C approach prior to PEPFAR to the balanced ABC strategy. The Emergency Plan has implemented this more comprehensive strategy, one that reflects the growing body of data that validate ABC behavior change. PEPFAR has followed Congress' mandate that it is possible and necessary to strongly emphasize A, B, and C, while also seeking to support prevention of mother-to-child transmission and other critical prevention interventions.

The Congressional directive, which itself reflects an evidence-based, public health understanding of the importance of ABC, has helped to support PEPFAR's field personnel in appropriately broadening the range of prevention efforts. Solid policy guidance from PEPFAR on prevention has helped to address many issues of concern. In addition, the directive has helped PEPFAR to align itself with the strategies of host nations, of which ABC is a key element.

The Emergency Plan recognizes the importance of tailoring prevention efforts to the particular epidemic of each country, consistent with the requirement that 33% of prevention funding support AB activities. As the GAO Report notes, PEPFAR offers each focus country team the opportunity to propose, and provide justification for, a different prevention funding allocation based on the circumstances in that country.

To date, all such justifications have been approved. PEPFAR has been able to approve these while continuing to ensure that the focus countries as a whole continue to comply with the Congressional directive – and has done so without requiring other countries to make offsetting adjustments to their proposed prevention allocations.

It is important to remember that most focus countries have generalized epidemics, for which the ABC approach is the most effective, data-based strategy. Every country has the opportunity to submit a justification, but in those with generalized epidemics for which ABC has been proven to be so effective, the justification for a different allocation must be particularly strong. It is also important to remember that the U.S. Government is not the only source of funding in-country, and that partners can seek funding from other sources to balance their mix of prevention interventions if they find that necessary.

In fact, while many now recognize that the evidence supports a balanced ABC approach, money does not always follow the evidence. As the Minister of Health of Namibia noted in a recent letter to the editor of the Lancet, PEPFAR support for AB is needed to ensure the balanced ABC program that Namibia seeks. This is because other international partners support primarily C interventions.

Although the ABC approach reflects existing practice in many host nations, it has clearly represented a change in U.S. Government practice, and change always involves a period of transition. Yet we have asked some of the country teams that did not submit justifications if they wanted to do so and the answer was, emphatically, no. As country teams have become more experienced in the ABC approach and familiar with the data that supports it, they have become more comfortable implementing it.

Lastly, let me address the issue of how we are monitoring and evaluating our prevention efforts. We strongly believe that we need to focus not only on inputs but on results – the number of HIV infections averted due to PEPFAR interventions. Estimating the number of cases averted is challenging, because a case averted is a non-event. We are looking at the difference between something that is – the current level of HIV prevalence – and something that merely *would have been* – the level of HIV prevalence we'd be seeing today if the U.S. Government had not stepped in with massive scale-up of HIV prevention activities.

Obviously, we cannot measure directly the number of infections that would have occurred without U.S. Government support. One area of prevention for which we are using a model to estimate infections averted is prevention of mother-to-child transmission. Through March 2006, we supported programs that provided women with these services, including voluntary HIV counseling and testing, during more than 4.5 million pregnancies. It is noteworthy, by the way, that the number of women served with activities to prevent mother-to-child transmission grew dramatically from 821,000 in the first half of FY05 to almost 1.3 million in the first half of FY06.

In over 342,000 pregnancies, the women were identified as HIV-positive and given antiretroviral prophylaxis to prevent infection of their children. Using an internationally-agreed model, we estimate that this intervention averted approximately 65,100 infant infections through March of this year.

For prevention as a whole – including sexual and medical transmission -- we are working to develop the best possible models to allow us to estimate the number of infections that PEPFAR-supported programs have averted. These models will greatly enhance our ability to evaluate our progress toward our goal of 7 million infections averted by 2010.

Mr. Chairman, there has been a sense of fatalism about HIV prevention in many quarters. It is long past time to discard that attitude. The world community must come alongside governments, civil society, religious organizations, and others to support their leadership and the sustainability of their HIV-prevention programs through effective prevention. The U.S. Government, for our part, considers it a privilege to do so.

The initial years of the Emergency Plan have demonstrated that high-quality prevention programs can work – and are working – in many of the world's most difficult places. Through PEPFAR, the American people have become true leaders in the world's effort to turn the tide against HIV/AIDS.

Mr. Chairman, thank you very much. I would be happy to address any questions.